

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 732

00595

## CERTIFICATE OF DEATH

Reg. Dist. No. 211

## 1. PLACE OF DEATH:

County

Howard  
Long Corner Inn

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Clara P. Brown

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White married

6. (b) Name of husband or wife

Clara C. Brown

7. Birth date of deceased (mo., day, yr.)

1896 June 24

8. (c) If alive, give age 50 years

8. AGE:

Years Months Days It less than one day  
49 6 9 hrs. min.

9. Birthplace

Montgomery County, Maryland

(Town, county, and state)

10. Usual occupation

Home Wife

11. Industry or business

Home

FATHER

12. Name William A. Brall

MOTHER

13. Birthplace Montgomery Co., Md.

14. Maiden name

Virginia C. Walker

15. Birthplace

Montgomery Co., Md.

16. Informant

Clara P. Brown

Address

Mt. Airy Inn

Burial

Date thereof Jan 5 - 1945

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or cemetery

Montgomery

Location

Claytonville Road

18. Funeral director

Bob W. Barber

Address

Deltaville, Virginia

19.

Jan 5 - 1945 Della N. Burdette

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland County Howard

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 2 1945 at 11:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 19 1947 to January 2 1945

and that I last saw her alive on January 2 1945

Immediate cause of death cerebral hemorrhage

DURATION

3 hours

Due to Arteriosclerotic - hypertensive cardio-vascular disease

10 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings af operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

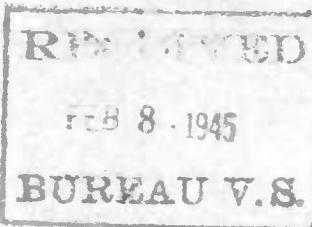
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James P. Kerr M.D.

M. D. or other

Address Damascus, Md. Date signed 1/2/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00596

## CERTIFICATE OF DEATH

Reg. Dist. No.

193

## 1. PLACE OF DEATH:

County ..... *Howard*  
 Near ..... *Ridgeville*  
 City or town .....  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ..... *50 years.*

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

*Mrs. Ida Z. Burdette*

## 3. (b) Social Security Number

## 4. Sex

Female | Color or race *White* | 6.(a) Single, married, widowed, or divorced  
*MARRIED.*

## B.(b) Name of husband or wife

*W. Frank Burdette*

## 7. Birth date of deceased (mo., day, yr.)

88. Birthdate *April 6, 1859*6.(c) If alive, give age ..... *87* years

## 8. AGE:

Years	Months	Days	If less than one day
<i>85</i>	<i>9</i>	<i>6</i>	hrs. min.

## 8. Birthplace

*Howard Co. MARYLAND.*

(Town, county, and state)

## 10. Usual occupation

*Housewife.*

11. Industry or business

12. Name *Andrew J. Mullinix*13. Birthplace *MARYLAND.*14. Maiden name *Susie Jane Beeraft*15. Birthplace *MARYLAND.*16. Informant *Mr. W. Frank Burdette*Address *Mt. Airy. Md.*17. Burial Date thereof *1-14-45*  
 (Burial, cremation, or removal, which?) Date (month) (day) (year)Cemetery or cemetery *Montgomery Chapel*Location *Claytonsville, Montg. Co. Md.*18. Funeral director *G.W. Waltz*Address *Waufield, Md.*19. Date rec'd by registrar *Jan - 18 1945 E. Paul Morris*

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State *Maryland* County *Howard*

City or town *Rural - Ridgeville.*  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. *P. D. Mt. Airy. Md.*  
 (If rural, give LOCATION)

## 2.(a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH *JAN. 12 1945*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *June 1941* to *Jan. 12 1945*and that I last saw her alive on *January 11* 1945Immediate cause of death *Cardiac Thrombosis*Duration *2 days*Due to *Arterio - Sclerosis.*Due to *Hemiplegia*Duration *3 yrs.*Other conditions *Hemiplegia*

(Include pregnancy within 8 months of death)

Major findings of operations *none*Date of op. *none*Autopsy results *none*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

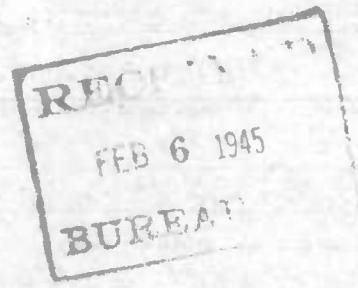
22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....  
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *Stanley Grable*M. D. *Stanley Grable*Address *McArdle, Md.* Date signed *1/22/45*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00597

## CERTIFICATE OF DEATH

Reg. Dist. No. 190

## 1. PLACE OF DEATH:

County

City or town

Howard

Elkridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

3 yrs

Hospital, institution, or street address where death occurred:

Loudon Ave, Harwood Park

How long in hospital or institution?

## 3. (a) FULL NAME

Rose Ella Edmonston

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Frank E. Edmonston

7. Birth date of deceased (mo., day, yr.)

8.(c) If alive, give age

years

Dec 25 1891

8. AGE:

Years

Months

Days

If less than one day

hrs. mil.

63

0

20

9. Birthplace

Ellicott City Md

(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

Domestic

FATHER

Albert King

13. Birthplace

Scarsdale N.Y.

MOTHER

Louisa Dwyerigan

14. Maiden name

Ireland

15. Birthplace

16. Informant

Mrs. Zestrelle, Mary Carter

Address

Harwood Rd, Elkridge 22nd

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Glenwood Cemetery

Location

Washington D.C.

18. Funeral director

The J. H. Hayes Co

Address

2901 - 14 st n.w. Washington D.C.

19. January 15 1945

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Howard

City or town

Elkridge

(If outside city or town limits, write R.R. # and give nearest town)

Street No

Loudon Ave

Harwood Park

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 14

1945, at 11:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 25

1944, to Jan 14

1945

and that I last saw her alive on

Jan 14

1945

Immediate cause of death

Cardiovascular disease

1 day

Due to: Chronic Myocarditis 4 mo

Anterior Hypertension

Due to: Obstruction 2 yrs

Other conditions

none

(Include pregnancy within 3 months of death)

Major findings or operations

none

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

B.B. Brumback M.D. or other

Address: 5609 main st Address: Elkridge Md Date signed: 1/15/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for charge of  
FILM NO. G 94 APR 7 1945

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH <sup>77-c</sup>

Registered No. 155

## 1. PLACE OF DEATH:

(a) ~~City~~ Maryland *Howard Co.*  
(b) Street address *Laurel, Md.*  
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

## 3 (a) FULL NAME

*Elvord N Fisher*  
3 (b) If veteran, name war  
*World War I*      3 (c) Social Security Account No.

4. Sex *Male*      5. Color or race *White*      6 (a) Single, married, widowed, or divorced. *Single*

6 (b) Name of husband or wife *Single*6 (c) If alive, give age years *76*7. Birth date of deceased (mo., day, yr.) *Jul 16, 1896*8. AGE: Years *48* Months *5* Days *10* If less than one day *36* by *1* min.9. Birthplace *Laurel, Md.*  
(Town, county, and state)10. Usual Occupation *Clerk*11. Industry or business *Race tracks*12. Name *Elvord N Fisher*13. Birthplace *Savage, Md.*14. Maiden Name *Elvora A. Fisher*15. Birthplace *Savage, Md.*16 (a) Informant *Elvord N. Fisher*16 (b) Address *Laurel, Md.*17 (a) Burial *Burial* (b) Date thereof *Jan 13, 1945*  
(Burial, cremation, or removal) (month) (day) (year)17 (c) Cemetery or crematory *Elvry Hill*Location *Laurel, Md.*18 (a) Funeral director *Alfred W. McDonald*18 (b) Address *Laurel, Md.*19 (a) Death certificate registrar *A. W. Petrich*  
(Date issued) *1/15/45* (Signature) *per M. D.*

## 2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.* (b) County *Howard*  
(c) City or town *Laurel*  
(If outside city or town limits, write RURAL and give town)  
(d) Street No. *120*  
(e) Citizen of foreign country? *No* (Yes or No)  
If yes, name country:

## MEDICAL CERTIFICATION

20. DATE OF DEATH *January 11 1945*, at *9 A.M.*

21. I certify that I took charge of the remains described above, held an *Autopsy* thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to *his* death on the day stated above, and death in my opinion resulted from: natural causes , accident , suicide , homicide , undetermined  and that the causes of death were:

## IMMEDIATE CAUSE OF DEATH

*Acute alcoholism, C. & S.P.**Pneumonia*

Due to:

## Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary  or contributing  cause of death, fill in the following:

(a) Date of injury ..... at ..... M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature *Robert L. Gruber M.D.*  
Medical Examiner  
Date signed *Jan. 11 1945*

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00599

192

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15

## 1. PLACE OF DEATH:

County Maryland

City or town Woodstock

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Alice Bentley

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M.

W

Married

6. (b) Name of husband or wife

Nathaniel Harrison Bentley

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 28, 1870

8. AGE:

Years

Months

Days

If less than one day

74

5

7

hrs.

min.

9. Birthplace

(Town, county, and state)

Woodstock

10. Usual occupation

Housewife

11. Industry or business

At Home

MOTHER FATHER

12. Name

Andrew Jackson

13. Birthplace

Md.

14. Maiden name

Ellen Jones

15. Birthplace

Md.

16. Informant

Mrs. Norman Bentley

Address

Woodstock, Md.

17. Burial

Date thereof June 8, 1945

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Mt. View Cemetery

Location

Howard Co., Md.

18. Funeral director

C. Harry Wee

Address

Lykensville, Md.

19. Date rec'd by registrar

Jan. 7, 1945 C. Harry Wee

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County Howard

City or town Woodstock

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## MEDICAL CERTIFICATION

2D. DATE OF DEATH

1 - 4 1945 at 10 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

1 - 4 1945 to 1 - 4 1945

and that I last saw h.c.r. alive on No date

Immediate cause of death

Hypertensive Cardiac Disease  
Cerebral Hemorrhage

DURATION

6 years  
15 months

Due to

Due to

Other conditions

none

(Include pregnancy within 8 months of death)

Major findings or operations

none

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

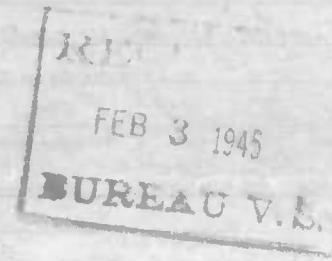
Means of injury

Injured at work?

23. SIGNATURE George E. Bentorf, M.D.

DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY OR OTHER

Address Elliott City, Md. Date signed 1-4-45



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00600

## CERTIFICATE OF DEATH

195

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:  
 County HOWARD  
 City or town WATERLOO Jesusup, R.F.D.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 week  
 Hospital, institution, or street address where death occurred: WASHINGTON BLVD. ROUTE 1 - ONE SPOT  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State MARYLAND County HOWARD, Jesusup R.F.D.  
 City or town ROUTE 1, WATERLOO - ONE SPOT  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street no. PRIVATE - UNABLE TO LOCATE  
 (If rural, give LOCATION)  
 REGULAR ADDRESS - AT ABOVE ADDRESS 1 WEEK  
 2.(a) Veteran, non-veteran

## 3. (a) FULL NAME

JOHN STEVEN JACKSON

4. Sex <u>M</u>	5. Color or race <u>W</u>	6.(a) Single, married, widowed, or divorced <u>UNKNOWN</u>
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6.(b) Name of husband or wife UNKNOWN7. Birth date of deceased (mo., day, yr.) ? 1897 6.(c) If alive, give age years8. AGE: Years 48 Months ? Days ? If less than one day hrs. min.9. Birthplace UNKNOWN  
(Town, county, and state)10. Usual occupation LABORER

11. Industry or business

12. Name UNKNOWN13. Birthplace "14. Maiden name "15. Birthplace "16. Informant MARYLAND STATE POLICEAddress WATERLOO - MD.17. BURIAL Date thereof Jan. 29, 1945  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory GOOD SHEPHERDLocation FELICITY CITY MD.18. Funeral director F.C. HIAZIN BATHOMAddress FELICITY CITY MD.19. 1/29/45 (Date rec'd by registrar) Frank Shigley (Registrar)

## 3. (b) Social Security Number

266-16-4917

## MEDICAL CERTIFICATION

20. DATE OF DEATH JAN. 8, 1945 at 7 A.M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 8, 1945 to Jan. 8, 1945  
and that I last saw him alive on no time.Immediate cause of death acute Alcoholism DURATION 3 days.

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 8 months of death)

Major findings of operations .....

Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of .....

Where did injury occur? (City or town) (County) (State)

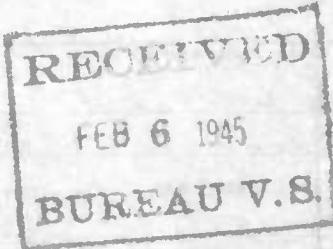
Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Frank Shigley, M.D. M. D. or other

acting Deputy Med. Examiner for Howard Co.

Address Savage, Md. Date signed 1/29/45



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

73-2

00601

## CERTIFICATE OF DEATH

Reg. Dist. No. 191

## 1. PLACE OF DEATH:

County

Howard  
Ellicott City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex      5. Color or race      6. (a) Single, married, widowed, or divorced

Male      White      Married

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

June 9, 1886

8. (c) If alive, give age ..... years

8. AGE:      Years      Months      Days      If less than one day

58      7      19      hrs.      min.

9. Birthplace

Hawood Co. of Carolina

(Town, county, and state)

10. Usual occupation

Lumberman

11. Industry or business

Retail

12. Name

Joseph McEntyre

13. Birthplace

Canton, North Carolina

14. Maiden name

Sarah Lillie Anna Reynolds

15. Birthplace

Canton, North Carolina

William McEntyre

Address

Ellicott City, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

St. Johns Cemetery

Location

Ellicott City, Md.

18. Funeral director

Easton Sons

Address

Ellicott City, Md.

19. Date rec'd by registrar

John B. Loughran

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

None

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan. 28, 1945, at 3 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 1, 1943, to Jan 28, 1945,

and that I last saw h. m. alive on Jan 28, 1945.

Immediate cause of death

Bronchial pneumonia

Chronic bronchitis

Due to

Beriberi

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John Loughran, M.D.

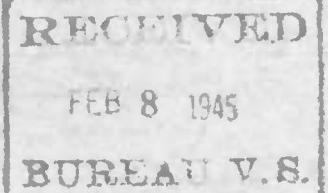
M. D. or other

Address

Ellicott City, Md.

Date signed Jan 30, 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

00602 P

## CERTIFICATE OF DEATH

Reg. Dist. No. 190

## 1. PLACE OF DEATH:

County

City or town

Howard

Elkridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

19 yrs

Hospital, institution, or street address where death occurred:

6106 old Wash Blvd.

How long in hospital or institution?

## 3. (a) FULL NAME

Elizabeth Ann Seven

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female white Widowed

## 6.(b) Name of husband or wife

Geo Seven

7. Birth date of deceased (mo., day, yr.)

Feb 19 1856

## 8. AGE:

Years

Months

Days

If less than one day

88

10

24

hrs. min.

## 9. Birthplace

Bristol England

(Town, county, and state)

## 10. Usual occupation

Domestic

## 11. Industry or business

Retired

## 12. Name

Stephen Thomas

## 13. Birthplace

England

## 14. Maiden name

Elizabeth Seven

## 15. Birthplace

England

## 16. Informant

Mrs Stephen Seven

## Address

6106 old Wash Blvd Elkridge Md.

## 17. Burial

Date thereof 11/16/45

## (Burial, removal, etc.)

(month) (day) (year)

## Cemetery or crematory

Grace Church

## Location

Elkridge Md.

## 18. Funeral director

William Cook Inc.

## Address

1217 St. Paul St

## 19. (Date rec'd by registrar)

1-15 45 Decedent

## (Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County Howard

City or town

Elkridge

(If outside city or town limits, write RURAL and give nearest town)

Street No.

6106 old Washington Blvd

(If rural, give LOCATION)

2.(a) If veteran, name war

none

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 12 1945 at 11 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1944 to Jan 12 1945

and that I last saw her alive on Jan 12 1945

Immediate cause of death

Chronic bronchitis 2 yrs

acute glaucoma

Due to

General arteriosclerosis

Due to

arterial hypertension 5 yrs

Other conditions

Diabetes

(Include pregnancy within 3 months of death)

Major findings of operations

none Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B.B. Brumbach M. D. or other

Address 1609 Main St Elkridge Md Date signed 11/12/45

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 157-2

00603

Reg. Dist. No. 192

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County HowardCity or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Melvin Eugene Reese4. Sex M5. Color or race W6. (a) Single, married, widowed, or divorced S

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

December 24, 1944

6. (c) If alive, give age ..... years

8. AGE: Years

Months

Days

If less than one day

17 hrs. min.9. Birthplace Bethesda, Md.

(Town, county, and state)

10. Usual occupation None

11. Industry or business

12. Name John Reese13. Birthplace Md.14. Maiden name Ignes Condon15. Birthplace Md.16. Informant Mrs Ignes ReeseAddress Bethesda, Md.

17. Burial

Date thereof Jan. 14, 1945  
(Burial, cremation, or removal. Which?) Date (month) (day) (year)Cemetery or crematory Mount View CemeteryLocation Howard Co., Md.18. Funeral director C Harry LeeAddress Sykesville, Md.19. On: Jan. 13f. 4.5

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.County HowardCity or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Jan. 12 1945 at 2 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 6/4 1944 to Dec. 24 1945and that I last saw h. alive on Dec. 24 1945

Immediate cause of death

Meningitis

Due to

Spirra Bifida

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

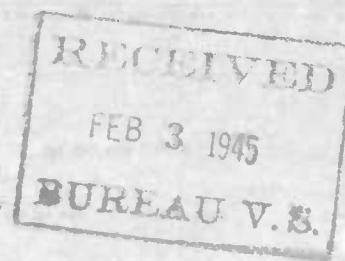
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

C. Lee  
M. D. or other  
Address Bethesda, Md. Date signed Jan 17/45



M

MARGIN RESERVED FOR BINDING

1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

## CERTIFICATE OF DEATH

00604

195

Reg. Dist. No.

## 1. PLACE OF DEATH:

County.....

City or town..... RURAL - LAUREL

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years

Hospital, institution, or street address where death occurred:

ROUTE #1 - Box 269 - LAUREL, MD

How long in hospital or institution?

## 3. (a) FULL NAME

JOHN LAWRENCE STONER

## 3. (b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

M

W

SINGLE

## 6.(b) Name of husband or wife..... ✓

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age..... years

AUGUST 22 1934

8. AGE: Years Months Days If less than one day

10 5

hrs. min.

9. Birthplace.....

PITTSBURGH - ALLEGHENY PARK

(Town, county, and state)

10. Usual occupation.....

SCHOOL AGE

11. Industry or business

12. Name JOHN R. STONER

13. Birthplace TIFFIN - OHIO

14. Maiden name RUTH M. KENNEDY

15. Birthplace COLUMBUS - OHIO

16. Informant JOHN R. STONER

Address RT #1 - Box 269 - LAUREL, MD.

17. BURIAL

(Burial, cremation, or removal. Which?)

Date thereof JANUARY 25 1940

(month) (day) (year)

Cemetery or crematory ST. MARY'S CEMETERY

Location LAUREL - MARYLAND

18. Funeral director

Address Robert D. McGehee

19. 1/24/45

(Date rec'd by registrar)

Frank Shirkley

Registrat

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... MARYLAND

County..... HOWARD

City or town..... RURAL - LAUREL

(If outside city or town limits, write RURAL and give nearest town)

Street No. ROUTE #1 - Box 269

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 22 1940 at 9:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 1944, to Jan 22 1940

and that I last saw him alive on Jan 22 1940

Immediate cause of death.....

Lymphatic Leukemia, acute (72a)

DURATION

4 mo

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work?

23. SIGNATURE

Robert D. McGehee

M.D. or other

Address

Date signed

